EXHIBIT 27

DETYENS SHIPYARDS, INC. – ACCIDENT/INCIDENT REPORT		
ACCIDENT/INCIDENT LOCATION (VESSEL/FACILITY)	USNS 1ST Lt. Jack Lummus (T-AK 3011), Main Deck, Stbd., Approx. Frame 240	
REPORT NO.	DATE/TIME OF ACCIDENT/INCIDENT	DATE OF REPORT
9093-1	04/03/2019, Approx. 0920 Hrs.	04/03/2019 – 04/08/2019

GENERAL SUMMARY OF ACCIDENT/INCIDENT
Crush incident resulting in fatality when retraining cable attached to # 6 Stbd. davit arm assembly separated aboard USNS 1ST Lt. Jack Lummus (T-AK 3011), Main Deck, Stbd., Approx. Frame 240

PERSONNEL INVOLVED/HAVING KNOWLEDGE OF ACCIDENT/INCIDENT		
NAME (Print)	DEPARTMENT	PAY #
Hubert L. "Chuck" Lynch	DSI Hull	3320
Tireashia Miller (Firewatch)	HiTrak Staffing	3799
Franklin Thomas, Jr. (Outside Machinist)	HiTrak Staffing	4822
Darrell Prater	HiTrak Staffing	1562
Renzo Fasce	US Coatings	
Ashlee Miller	Eagle Marine	0813
Patrick Smith (Rigger)	HiTrak Staffing	7328
Jose R. Guilarte Ruiz-Labrandera	US Coatings	
Wayne "Maytag" Matababas	DSI EHSO	1409
Thomas Wesley Mooney	DSI EHSO	3105
James Justin Lyles	DSI EHSO	3111
Ricky Desjardins	DSI EHSO	5599
Wm. Michael Marshall	DSI EHSO	1552

ACCIDENT/INCIDENT REPORTED BY	ACCIDENT/INCIDENT REPORTED TO
John Rivers, DSI Rigging Supervisor	DSI EHSO notified of need for help via walkie-talkie

DETYENS SHIPYARDS, INC. – ACCIDENT/INCIDENT REPORT # 9093-1

INJURED EMPLOYEE(S) INFORMATION	
INJURED EMPLOYEE NAME	Jose De Jesus Pena* (Name provided at hire with Southern Skills Trades)
DEPARTMENT/POSITION(TITLE)	Subcontract structural welder (Hull Department)
EMPLOYEE AGE/DATE OF BIRTH	05/05/1990* (Date of birth provided at hire with Southern Skills Trades)
HIRE DATE	Hired through HiTrak Staffing 12/28/2015
HOURS WORKED DATE OF INJURY	Shift started 0700 Hrs.
WORK STATUS AT TIME OF INCIDENT	Employed on normal shift
MEDICAL TREATMENT	N/A
MEDICAL DIAGNOSIS	Fatality
LOST TIME INJURY (LTI), RESTRICTED WORK CASE INJURY (RWI)	N/A

DETAILED DESCRIPTION OF ACCIDENT/INCIDENT

12/15/2018: USNS Lummus docked in Drydock # 5. Lifeboats had been removed from vessel; davit arms had been restrained with ½" cable and Crosby clamps prior to entering dock. Vessel arrived DSI facility on or about 11/19/2018. USNS Lummus repair specifications, Item # 601, Para. 6.1, states "remove all lifeboats from the davits and stow ashore on Contractor furnished cradles within 24 hours of vessel arrival at Contractor's facility."

04/03/2019:

0700: Employee shift start. Attended Daily Job Safety (Hazards) Analysis briefing and reported to USNS Lummus worksite (# 6 Stbd. boat davit)

0900: Hotwork permit issued and posted. Employee was preparing worksite to commence hotwork activities

0920: Employee was reported sitting on a 5-gallon bucket atop the 55G-MKII winch assembly when the # 6 davit arm restraining cable parted, pinning employee between the davit arm and the davit arm trackway. Supervisor Chuck Lynch, DSI Hull Quarterman, stated he and other employees in area attempted to pull the davit arm off of employee by employing rope. Mr. Lynch stated that he called rigging supervisor on pier to swing crane to over to aid in removing the davit arm atop employee

0932: DSI EHSO personnel received call over walkie-talkie for assistance aboard USNS Lummus. DSI EHSO immediately responded to incident scene at # 6 Stbd. boat davit on main deck

0940: DSI EHSO personnel arrive at worksite. Employee had been freed from entrapment and was laying on the deck inboard of the boat davit. DSI EHSO personnel began resuscitation efforts. Bag Valve Mask (BVM) and chest compressions were started. AED was employed once, BVM and compressions continued. AED was being charged to administer 2nd charge when AED advised "Not to Shock" indicating a suitable heart rhythm was not detected by instrument

0950: Rescue basket was landed on deck aft of the boat davit. Compressions and BVM use continued

0955: US Federal OSHA was notified of incident and requested response. OSHA inspector stated he had just arrived the FLETC complex at the south end of the facility and would respond immediately

Employee was placed into rescue basket accompanied by two members of the DSI EHSO and two members of the North Charleston Fire Department and lowered to the pier upon which it was determined to terminate resuscitation efforts.

DETYENS SHIPYARDS, INC. – ACCIDENT/INCIDENT REPORT # 9093-1

DETAILED DESCRIPTION OF ACCIDENT/INCIDENT - continued

Incident scene was immediately secured both forward and aft. Access was restricted and no materials/equipment was removed from the area. DSI EHSO personnel remained as security of area until relieved by North Charleston Police Department Officers.

Investigation was conducted by US Federal OSHA, USCG, North Charleston Crime Investigators and the Charleston County Coroner's Office. Charleston County Coroner's Office found and retained employee's wallet and cell phone. Coroner's office also took possession of the restraining cable after being removed by USCG and vessel crew members.

ROOT CAUSE ANALYSIS (Check All That Apply)

Improper Work Technique		Poor Housekeeping	
Safety Rule Violation		Excessive Noise	
Improper PPE or PPE Not Used		Inadequate Guarding of Hazards	
Operating Without Authority		Defective Tools/Equipment	
Failure to Warn or Secure		Improper Isolation	
Operating at Improper Speeds		Insufficient Lighting	
By-Pass of Safety Devices		Inadequate Fall Protection	
Guards Not Used		Lack of Written Instructions	X
Improper Loading or Placement		Safety Rules Not Enforced	
Improper Lifting		Hazards Not Identified	X
Servicing Machinery In Motion		PPE Unavailable	
Horseplay		Insufficient Worker Training	
Drug or Alcohol Use		Insufficient Supervisor Training	
Unnecessary Haste		Improper Maintenance	
Unsafe Acts of Others		Inadequate Supervision	
Poor Workstation Design/Layout		Inadequate Job Planning	
Congested Work Area		Inadequate Hiring Practices	
Hazardous Substances		Inadequate Worksite Inspection	
Fire/Explosion Hazard		Inadequate Equipment	
Inadequate Ventilation		Unsafe Design/Construction	
Improper Material Storage		Unrealistic Scheduling	
Improper Tool/Equipment		Poor Process Design	
Insufficient Knowledge of Job		Procedure Violation	
Slippery Conditions		Inattention To Detail	X
		OTHER (list):	
		Taking an unsafe position or posture	X

DETYENS SHIPYARDS, INC. – ACCIDENT/INCIDENT REPORT # 9093-1

CORRECTIVE ACTION
(1) All work secured. Safety stand-down conducted
(2) Additional restraining wires were installed around the davit arms
(3) Structural chocks were installed and welded in trackway in front of davit arm assembly rollers
(4) DSI to develop and implement SOP for davit arm restraint by COB 04/19/2019. In interim, 2 means of restraining davit arms will be employed

CONSEQUENCES OF ACCIDENT/INCIDENT
(1) Injury/death
(2) Loss production time during investigation, recovery and implementation of additional safety restraints
(3) Schedule delay
(4) Investigation and determination of root cause of incident

ADDITIONAL NOTES/REMARKS
(1) Approx. 1820 Hrs, 04/03/2019, Charleston County Corner notified US Federal OSHA that deceased was not believed to be Jose De Jesus Pena, DOB 05/05/1990, but was suspected to may be Juan Antonio Villalobos-Hernandez, DOB 09/22/1975. Corner has turned information over to Immigrations and Customs Enforcement for assistance in identification.
(2) Davit arm assembly weight – approx. 3700 lbs.
(3) Tensile strength ½" stainless steel cable

REPORT PREPARED BY	SIGNATURE	DATE
Wm. Michael Marshall		04/09/2019
REPORT REVIEWED BY	**SIGNATURE**	**DATE**
Wm. Michael Marshall		04/09/2019

OPERATIONS MANAGER REVIEW		
REPORT STATUS	( ) ACCEPT ( ) REVISE	
	SIGNATURE	DATE
REVIEWED BY DSI Vice President of Operations		